

**ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
FOLLOW-UP APPLICATION**

(Under Provision of A.A.C. R9-6-401, et seq)

The information contained in this document is confidential under the provisions of A.A.C. R9-1-311, et seq

CLIENT INFORMATION: I am a resident of Arizona ____ YES ____ NO

Name: _____ Birthdate: ____/____/____
First Middle Last Month Day Year

Residential Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone Number: (____) _____ Secondary Phone Number: (____) _____ Gender: _____

My current total annual family income from all sources is \$ _____ (include income for all adult family members), and the number of persons in my family, including myself, is _____. (The definition of family is two or more persons living together who are related by birth, marriage or adoption.) Please list names and ages of family members: 1. _____ 2. _____
3. _____ 4. _____ 5. _____ 6. _____

CURRENT EMPLOYMENT STATUS: [] Private/Public Employer [] Self-Employed [] Unemployed

[] Other (specify) _____

I am currently receiving benefits from the Arizona Health Care Cost Containment System (AHCCCS). ____ NO ____ YES

Are you eligible for Medicare ____ NO ____ YES When will you become Medicare eligible? _____

I currently have health insurance that would pay for all or part of the cost of medications provided by this program. ____ NO

____ YES (IF YES, ____ PART OR ____ ALL)

I, _____, certify that to the best of my knowledge and belief, all statements made herein regarding personal and other non-medical information are true and accurate. I certify that I am or my child or ward is not covered by any health insurance plan that would provide the support for which I am or my child or ward is applying. I understand that eligibility does not guarantee that the Arizona Department of Health Services will be able to provide support and that such support, if begun, may be terminated without notice. I grant permission to ADHS to use my name in discussing my application with the AHCCCS office, for purposes of determining AHCCCS eligibility; Medicare and the Social Security Administration, for the purpose of determining eligibility for low income subsidy; the vendor pharmacy, to assist with drug distribution; primary care provider; or, any other entity required to establish or assist with drug distribution.

Applicant's Signature

Date

TO BE COMPLETED BY HEALTH CARE PROVIDER:

HEALTH CARE PROVIDER'S NAME: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) - ____ - _____ FAX NUMBER: (____) - ____ - _____

Treatment with therapeutic agents is still appropriate for the above client.

Latest CD₄ cell count _____ DATE _____ VIRAL LOAD TEST RESULTS (If available) _____ DATE _____

I certify that to the best of my knowledge and belief all medical information presented by me in this application is true and accurate.

Health Care Provider's Signature

Date

RETURN TO: OFFICE OF HIV, STD, Hepatitis C Services
AIDS Drug Assistance Program (ADAP)
150 North 18th Avenue, Suite 110
Phoenix, AZ 85007-3233
(602) 364-3610 / (800) 334-1540
FAX: (602) 364-3263
Revised 4/16/07
